COMBINED OPERATION FOR THE REMOVAL OF THE APPENDIX AND THE CURE OF RIGHT INGUINAL HERNIA.[1]

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HAVING had a number of patients upon whom I had to operate both for chronic appendicitis and right inguinal hernia, the two operations being performed at different times, it occurred to me that it would be in the patient's interest to combine the two operations in one if possible. On one occasion, where I had a large hernial opening, I attempted to bring down the appendix into the hernial opening, a procedure which suggested itself through the fact that the appendix is occasionally found in a hernial sac. The attempt, however, proved to be an absolute failure. Thereupon I devised the operation following. It consists simply in extending the skin incision somewhat higher up than usual for hernia operations, in dividing the fascia of the external oblique about at the usual place for the gridiron operation for appendicitis, but extending it downward into the external inguinal ring, and then completing the operations for hernia and for appendicitis in the usual way.

To describe the operation more in detail, it is performed as follows: An imaginary line is drawn from the anterior superior spine of the ilium to the umbilicus. A point on this line at a distance equal to one quarter of its length from the iliac spine marks the beginning of the incision, which is carried down from here to the external inguinal ring. The aponeurosis of the external oblique is exposed throughout the length of the incision. This fascia is now incised in the direction of its fibres, as is customary in the gridiron operation for appendicitis, exposing the internal oblique muscle; but the incision is prolonged downward so as to terminate at the apex of the external inguinal ring. The aponeurosis of the external oblique is prepared off from the underlying parts in the usual manner, on the outer side exposing Poupart's ligament. Then the hernia operation is proceeded with up to the point where the sac is cut off. Here the hernia operation is intermitted and attention turned to the appendix. The fibres of the internal oblique and transversalis are separated bluntly in the usual manner, the peritoneum is opened, the appendix removed; then the peritoneum, transversalis fascia, and muscles are closed again; in a word, the appendicitis operation is completed, except that the aponeurosis of the external oblique is still left open.

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We now return again to the hernia operation and suture the internal oblique and transversalis to Poupart's ligament according to any of the approved methods, and finally suture the aponeurosis of the external oblique in the entire extent of its incision, so as to close both the appendicitis and the hernia operation. Lastly, the skin is sutured.

One might ask why, after incising the aponeurosis of the external oblique, one should not first perform the appendicectomy and then do the hernia operation ? This seems to me to be less advisable, because in operating on the hernia a considerable amount of traction is apt to be made on the sac, and this traction may invalidate the suture by which the peritoneum was closed over the appendicitis operation, whereas, on the other hand, if the sac is closed first and the appendicitis operation performed next, there is so little traction on the peritoneum during the latter operation that it will not interfere with the soundness of the closure of the neck of the sac.

Again, it might appear strange to some why, after closing the sac, we should turn our attention to the appendix, instead of at once putting in the sutures to unite the internal oblique and transversalis muscles to Poupart's ligament. The answer is, that this latter suture is a very delicate one, owing to the fact that the sutures embrace muscular tissue and that, during the efforts at bringing the appendix to the surface, the abdominal muscles may be subjected to rather extensive manipulation during which the muscle fibres could easily be injured where they had been sutured to Poupart's ligament.

The combined operation has decided advantages over the performance of the two operations at separate sittings. It saves the patient one operation and it takes only very little longer than the hernia operation alone would require, for, after the aponeurosis of the external oblique has been laid open so widely, the appendicitis operation is performed more easily, and therefore more rapidly, than where the usual short incision through the aponeurosis is made. Furthermore the combined operation will have a claim to greater firmness of the abdominal wall, as it is certainly better to have one incision in the aponeurosis than two. It goes without saying, that in those exceptional cases where the diseased appendix is situated within the hernial sac, the method described above is not needed.